TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
FedEx Freight, Inc.

MFDR Tracking Number
M4-15-4214-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Tramadol HCL 50 MG is **medically necessary**: … to decrease pain … to allow the patient to work … to allow activities of daily living …

Meloxicam 7.5 MG is **medically necessary**: … to decrease inflammation … to allow the patient to work … to allow activities of daily living … treatment of prolonged joint pain, Arthritis, Osteoarthritis due to injury."

Amount in Dispute: $222.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services on June 1 and July 3, 2015, were disputed based on the services not being medically reasonable and necessary for the compensable injury."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1 & July 3, 2015	Prescription Medication (Tramadol & Meloxicam)	$222.80	$215.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.3 sets out the requirements for communication related to medical bill processing.
3. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - F – Reduced according to fee guideline
   - D03 – Reviewed and denied by carrier or TPA.

Issues

1. Does an unresolved issue of medical necessity exist for this dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the total reimbursement amount for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On their position statement, the insurance carrier stated that the disputed services were denied for "not being medically reasonable and necessary for the compensable injury." 28 Texas Administrative Code §133.307 (d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   Review of the submitted documentation does not find that medical necessity was presented as a denial reason to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered.

2. The insurance carrier denied disputed services with claim adjustment reason code D03 – "REVIEWED AND DENIED BY CARRIER." 28 Texas Administrative Code §133.3 (a) requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill…" Review of the submitted information finds that this denial does not meet the requirements of 28 Texas Administrative Code §133.3 (a). The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount…
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider

   The requestor is seeking reimbursement for the generic drugs tramadol HCl 50 mg tablet, NDC number 16714-0111-12; and meloxicam 7.5 mg tablet, NDC number 68382-0050-05. The disputed medications were dispensed on June 1, 2015 and July 3, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
6/1/15	Tramadol HCl 50 mg tablet	(0.83545 x 60 x 1.25) + $4.00 = $66.66	$74.20	$66.66	$0.00	$66.66
6/1/15	Meloxicam 7.5 mg tablet	(3.16870 x 60 x 1.25) + $4.00 = $241.65	$74.20	$74.20	$0.00	$74.20
7/3/15	Meloxicam 7.5 mg tablet	(3.16870 x 60 x 1.25) + $4.00 = $241.65	$74.20	$74.20	$0.00	$74.20

4. The total reimbursement for the disputed services is $215.06. The insurance paid $0.00. A reimbursement of $215.06 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $215.06.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $215.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	September 24, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.